UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION SIX

THE MEDICAL CENTER[1]

Employer

and

Case 6-RC-11854

DISTRICT 1199P/SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Petitioner

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, a hearing was held before Patricia J. Daum, a hearing officer of the National Labor Relations Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its powers in connection with this case to the undersigned Regional Director.[2]

Upon the entire record[3] in this case, the Regional Director finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

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[1] The name of the Employer appears as amended at the hearing.

[2] Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 l4th Street, N.W., Washington, D.C. 20570-000l. This request must be received by the Board in Washington by September 11, 2000.

[3] The Employer and the Petitioner filed timely briefs in this matter which have been duly considered by the undersigned.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(l) and Section 2(6) and (7) of the Act.

The Petitioner seeks to represent a unit, as amended at the hearing, consisting of all full-time and regular part-time registered nurses, including the classifications of Clinical System Analyst, Disease Management Coordinator, Case Management RNs, RN-Peri/Op Facilitator, Nurse Anesthetist, RN Nerve Block Assistant, IV Therapists, Review Nurse, Nurse Practitioner, Blood Bank RN, Staff Nurse-Card/DI, Cardiac Rehab Nurse, Case Management/Wellness Center, ET Nurse, Family Planning Nurse, Family Planning Nurse Practitioner, Family Practice Nurse, Family Practice Nurse Practitioner, Clinical Process Coordinator, Educator RN, and Organizational Development Specialist RN, employed by the Employer at its facilities located at 1000 Dutch Ridge Road, Beaver, Pennsylvania, in Beaver Falls, Pennsylvania, and in Hopewell, Pennsylvania, excluding all office clerical employees, managerial employees, Clinical Nurse Specialists, Lead Nurses and the Employee Health Nurse, and guards, other professional employees and supervisors as defined in the Act.[4] The Employer, contrary to the Petitioner,

[4] The parties have stipulated, and I find, that the following individuals are excluded from the unit in that they possess the requisite criteria to be considered managerial personnel and/or supervisors under the Act: Anthony Checca, Manager of Anesthesia; Richard Thewes, Manager of Cancer Treatment; Rhonda Beltz, Lead in the Cardiac Cath Lab; Diane McClune, Cardiac Rehab Supervisor; Laurie Pile, Lead in Heart Work; Elizabeth Beatty, Lead in Cardiopulmonary; Robert Goda, Assistant Director of Cardiopulmonary; Diane Blakemore, Manager of Cardiology and Nuclear Operations; Ann Packer, Manager of Operations in Case Management; Bernadete Jordan, Director of Education; Terri Hardesty, Assistant Director of Critical Care; Joni Meiter, Director of Critical Care in Emergency; Kathy Byrne, Patient Care Coordinator in Family Practice; Louise Hiwiller, Director of Family Practice; Marilyn Hill, Manager of GI Lab; Kathleen Brenner, Director of Med/Surg; Karen Mayo, Assistant Director of GUS; Cynthia Sebastian, IV Therapy Supervisor; Katherine Glenz, Manager in Information Systems; Esther Hallas, Lead in Nursery; Maryanne December, Lead in Nursery; Ernestine Anderson, Nurse Supervisor; Mary Lee Chapas, Vice President of Patient Care Services; James Charron, Management Engineer in Nursing Administration; Delina Farelli, Nursing Supervisor; Carol Goehring, Nursing Supervisor; Francine Hixenbaugh, Nursing Supervisor; Eleanor McCanna, Nursing Supervisor; Beatrice Miller, Nursing Supervisor; Diane Petrick, Manager in Nursing Administration; Laura Allcorn, Manager of the Operating Room; Paula Garen Wissner, Lead in the Operating Room; Lydian Fisher, Assistant Director of

contends that the petitioned-for unit is inappropriate because the resource nurses[5] sought by the Petitioner are statutory supervisors. There are approximately 49 resource nurses and over 600 nurses in the petitioned-for unit. There is no history of collective bargaining for any of the employees involved herein.

The Employer is engaged in the operation of an acute care hospital in Beaver, Pennsylvania, and also operates a family practice facility in Beaver Falls, Pennsylvania and a rehab center in Hopewell, Pennsylvania.[6] The hospital is located in a 5-story building and has 350 beds. It employs about 2500 employees, including over 600 registered nurses.

The hospital is under the direction of Chief Operating Officer and Executive Director Walter Van Dyke. Reporting to Van Dyke are Mary Lee Chapas, Vice President of Patient Care Services, Terry Bliss, Vice President of Patient Care Services, and Fran Sheedy Bost, Vice President of Operations. Chapas has overall responsibility for a number of departments, including the six departments in which the resource nurses at issue herein are employed. Reporting to Chapas are a number of directors, and reporting to the directors are a number of assistant directors. As part of the hospital's supervisory hierarchy, there is a house supervisor on duty during the afternoon and night shifts. The house supervisor is available to respond to issues raised by the resource nurses during the off shifts, when other supervisory personnel are not normally available.

One of the duties of the resource nurses, described in detail below, relates to staffing adjustments. Such adjustments are called "flexing" and there is a hospital-wide flexing policy,

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Ortho/Neuro; Joanne Hatton, Manager of Outcomes Management; Thomas Deems, Supervisor of PACU; Maryanne Murtha, Lead in Nursery; Nancy Zismann, Director of Maternal and Child Health; Marcella Bartolovic, Nurse Manager of Psych Services; and Mark Metiko, Lead.

[5] While the disputed position is generally referred to as "resource nurse" in the hospital, in some departments it is referred to as "charge nurse". For convenience, the position is referred to herein as resource nurse, except in the discussion pertaining to those specific departments using the name charge nurse.

[6] The Employer is a division of Valley Medical Facilities. The other division of Valley Medical Facilities is the Sewickley Valley Hospital, which is not involved in the instant petition.

which has been adapted by the individual departments to meet their specific needs. Thus, each department at issue herein has a written flexing policy. There are also other hospital-wide policies, dealing with such issues as evaluations and raises, which are discussed in connection with the individual departments below.

a) The Cardiopulmonary Department

The cardiopulmonary department[7] is located on the third floor of the hospital and has 78 beds.[8] The department consists of three discrete areas, a 6-bed PTCA or angioplasty area, a 12-bed OHS or open heart area, with the remaining beds considered a general unit.

The cardiopulmonary department is under the direction of Joni Meiter, the Director of Critical Emergency Care Services.[9] Reporting to Meiter and responsible for the day to day operations of the cardiopulmonary department is Assistant Director Robert L. Goda. Reporting directly to Goda are two lead nurses (hereinafter leads), Mark Matiko and Betty Beatty.[10]

The leads work Monday through Friday on the daylight shift, but because of the nature of their duties, they are present on other shifts at times. The leads are considered the clinical experts in the department. As such, they are responsible for designing and teaching classes and implementing cross-training for the PTCA and OHS areas. They serve on various administrative committees, which deal with both clinical and managerial issues. As described more fully below, the leads participate in the disciplinary process and evaluate employees. In Goda's absence, they perform his functions. They also perform hands on patient care duties as the need arises. The leads wear a badge with the designation "lead".

[7] This department is also referred to as a "step down unit".

[8] Generally, during the week, 4 of the 78 beds are closed, and on the weekends, 10 beds are closed.

[9] Meiter's title is described in several different ways throughout the transcript; for convenience, one of those variations is used consistently in this decision.

[10] The parties have stipulated that the leads are excluded from the petitioned-for unit as supervisory and/or managerial employees.

The cardiopulmonary department has a total staff complement of approximately 170 employees. Staff working in this department include staff nurses, admission technicians who are responsible for admitting patients to the department, monitor technicians who are responsible for monitoring the transmitters worn by patients, and clinical technicians who are responsible for providing basic patient care and performing other duties. If the unit is full, on the daylight shift, there are 20 nurses, 7 clinical technicians, 2 monitor technicians, 2 admission technicians, and one resource nurse. Also working the daylight shift are Goda, the two leads, and an administrative specialist. On the afternoon shift, there are 16 nurses, 5 clinical technicians, 2 monitor technicians, 2 admission technicians, and one resource nurse. Goda or a lead may also be present for part of the shift. On the night shift, there are 14 nurses, 4 clinical technicians, 2 monitor technicians and one resource nurse.

The cardiopulmonary department employs a total of 10 resource nurses, 7 who are full-time employees and 3 who work part-time.[11] These nurses work about half of their scheduled shifts as resource nurses and about half as staff nurses. The resource nurses basically self-select their schedule, which is subject to modification by Goda.

The resource nurses are selected by Goda for the position. They receive no specialized training for the position; instead, they are oriented to the requirements of the position by an experienced resource nurse. They receive no extra pay or benefits for the position. They have no special designation on their badges as to their position, but are designated as resource nurses on the assignment sheets. They carry a cordless phone, have a designated phone number and have keys to locked cabinets[12] in the resource room.

The resource nurses are not regularly assigned patients. At the start of the shift, the oncoming resource nurse receives report from the outgoing resource nurse and at the end of

[11] The resource nurses are Chris Burkovic, Diane Campbell, Cathy Channels, Heide Johanson, Mary Kilhof, Kim Long, Mary Palovich, Tammy Rowse, Kim Russell and Carole Woods.

[12] The contents of the locked cabinets are discussed in the text infra.

the shift, gives report to the next resource nurse. The resource nurse rounds the floor to assess the workload of the staff and anticipate potential issues. When rounding, the resource nurse talks to the staff nurses, observes patients and reviews charts. She provides clinical information to other staff, and hands on assistance if needed.[13] She may also try to obtain other staff to provide assistance if needed. The resource nurses spend about half of their working time performing hands on patient care duties, and about half of their working time performing non-patient care duties. If the resource nurse observes a problem with the delivery of patient care, she will inform the staff member of the problem.[14] If the staff member refuses to correct the situation, the resource nurse does not issue discipline; rather, the resource nurse reports the matter to Goda.

As necessary, the resources nurses in the cardiopulmonary department will be in communication with other resource nurses throughout the hospital, generally regarding the status of patients, as for example whether a particular patient should be transferred to the cardiopulmonary department.[15] The resource nurses also interact with the housekeeping employees, and the housekeeping supervisor if necessary, regarding which areas must be cleaned at any given time.

The work schedules for the staff are prepared by Goda based upon self-schedules prepared by the staff. The scheduling of staff vacations is handled by Goda and his administrative assistant; the resource nurses do not schedule vacations. The resource nurses are responsible for reviewing computer generated staffing schedules covering a 4-week period,

[13] While resource nurses may act as preceptors in the orientation of new hires, other staff also perform this function. This is true not only in the cardiopulmonary department, but also in the other departments at issue herein.

[14] All staff nurses are responsible for attempting to correct such problems, but the resource nurse, in making rounds, has a greater opportunity to observe the delivery of care.

[15] The actual decision to transfer a patient is made by a physician.

and verifying that all of the information contained thereon is correct, considering such things as staff resignations, approved leave and trades among staff.

The resource nurses handle call offs. The resource nurses receive the call offs and complete a log detailing the information provided to them. They determine whether to replace the employee calling off, and if a replacement is needed, they obtain the replacement. The manner in which the resource nurses make these determinations is explained more fully below in connection with the discussion of the adjustments to the staffing schedule.

The resource nurses also handle the adjustments to staffing. As noted, the hospital has a flexing policy and this policy has been modified to reflect the needs of the cardiopulmonary department. The policy in effect in the cardiopulmonary department was developed by Goda with input from the resource nurses. The process utilized by the resource nurses in making staffing adjustments has two basic components, a determination of the appropriate staffing level, and a selection of employees whose schedules are affected.

Thus, in determining the appropriate level of staffing the resource nurse considers the department's printed guidelines for patient/staff ratio appropriate for the PTCA and OHS areas and the general unit.[16] The resource nurse considers the actual census as well as the anticipated admissions, anticipated transfers and anticipated discharges. For example, the resource nurse may have knowledge of anticipated admissions based on past trends and based on telephone conversations with other hospital personnel, such as emergency department staff. Further, in considering anticipated discharges, she may consider such factors as her knowledge of the patients' conditions and the physician's customary practice regarding discharges. Another factor in deciding upon the appropriate level of staffing is the acuity level of the patients,

[16] The patient/staff ratio for the general unit is, on the daylight shift, patients/nurses 4 to 1 and patients/ clinical technicians 8 to 1; on the afternoon shift, patients/nurses 5 to 1 and patients/clinical technicians 10 to 1; and on the night shift, patients/nurses 6 to 1 and patients/clinical technicians 12 to 1. During a period of transition between a former ratio and the ratio presently utilized, the resource nurses decided which ratio to use on a day to day basis.

and the resultant amount of nursing care required. In determining the acuity level, the resource nurse considers the information contained in the patients' charts, the reports of the staff nurses, as well as her own personal observation of the patients.

As noted, the resource nurse selects the staff whose schedule is impacted by the adjustments. These employees may be required to work when they had not been scheduled ("flex up"),[17] or may be directed not to report to work although they were scheduled to work ("flex down"). The procedure to be followed in the selection of employees is detailed in a policy directive available to the resource nurses.

In selecting employees whose schedules are thus impacted, the resource nurse would consider avoiding overtime, and various restrictions limiting the availability of staff for certain shifts (which restrictions may be related to health or discipline). The resource nurse would also consider when the employee was last impacted by a schedule adjustment and seniority. The information needed by the resource nurse to make decisions as to the selection of employees, such as records of leave restrictions, documents reflecting that certain employees are not to be scheduled, and flex logs are kept in a locked cabinet in the resource room.[18]

In making the selection, the resource nurse first seeks volunteers and if there are no volunteers, employees can be mandated to make the adjustment. In most cases involving additional work, there is a volunteer and it is not necessary to mandate an employee. At times, when additional staff is required, it may not be possible for the resource nurse to avoid overtime and the Employer will incur overtime as a result of the adjustment.

[17] Staff may also be placed on call. When on call, staff nurses are paid $2.25 per hour, and if they report to work, they are paid time and a half.

[18] The documents used by the resource nurse to determine the restrictions have been carefully tailored so as to reveal only the nature of the limitation, such as do not schedule a certain nurse for more than a certain number of hours, and do not reveal the reason for the restriction, be it leave or disciplinary, so as to keep the reasons confidential. In the cardiopulmonary department, there are currently about 30 employees with various medical restrictions affecting their availability to work.

These staff adjustments occur on a daily basis, in 4-hour increments.[19] They are made by the resource nurses without prior approval of the leads or Goda, although on occasion, a resource nurse will first discuss the matter with Goda. Ultimately, Goda is accountable for the staffing decisions made by the resource nurses, and he subsequently reviews their adjustments, and discusses any problem areas with them. Upper management in the hospital also reviews these records and may call upon a resource nurse to justify a staffing decision.

If an employee disagrees with an adjustment a resource nurse has made, the employee can approach Goda on the issue. If an employee refuses to work although mandated to do so, a 3-day suspension is imposed. In this situation, if the employee is refusing to work, the resource nurse first reminds the employee of the sanction, and if the employee still refuses, the resource nurse reports the refusal to Goda, who imposes the suspension.

Requests between staff to trade shifts are submitted to the resource nurse. These requests are routinely approved as long as they are equal trades, which do not result in overtime and occur within the same pay period. If these conditions are not met, the trade request is denied.

Requests for paid time off (hereinafter PTO) are typically handled by Goda, but in his absence or on weekends, the resource nurses may approve such requests. On the weekends, the request is usually made in connection with an employee calling off and requesting the use of PTO. The resource nurses also handle requests to leave early because of illness or emergency. If the request is denied, an employee can approach Goda to ask him to override the decision of the resource nurse.

The resource nurses decide where patients are placed on the floor. In making patient placement decisions, the resource nurse considers such factors as infections, acuity, age and mental status of the patient.

[19] Another staffing action taken by the resource nurse is obtaining a “sitter” from the nursing office for a patient, such as a suicidal patient, requiring one-on-one coverage.

The resource nurses assign staff to patients. The resource nurses do this by completing an assignment sheet to be used by the next shift. In making these assignments, the resource nurses consider patient/staff ratio, cross-training required to work in the PTCA and OHS areas, continuity of care,[20] acuity level of patients and resultant level of care required,[21] skill and experience level of staff, directives by Goda as to the placement of certain staff (e.g. do not assign nurse X and clinical technician Y together) and staff preferences as to working with certain types of patients as well as with certain other staff members. Further, the skill and experience of staff may be considered both as to pairing certain nurses with certain clinical technicians and as to assigning certain staff to certain patients. For example, a less experienced nurse may be assigned a more proficient clinical technician, or a less experienced nurse may be assigned less acutely ill patients to care for.

In addition to making the regular assignments, the resource nurse also completes special assignments, designating a nurse responsible for psych arrest, for the open heart crash cart, for the open chest cart, for the fire alarm, for the disaster plan, for the glucometers and for equipment.[22] The resource nurses to do not schedule lunch and break times; rather, the staff makes those decisions on their own.

The Employer maintains an attendance policy, under which tardiness can lead to discipline. The resource nurses generally have an opportunity to observe which staff reports to work late, and note the occurrence in logs, but do not issue any discipline. The Employer has recently switched to an automated time/attendance system from a paper record entered by staff themselves, and during this transition period, the department is currently utilizing both systems.

[20] The resource nurse may review the prior assignment sheet to see which nurses previously took care of which patients.

[21] Acuity and the resultant level of care required are considered in order to equalize work assignments.

[22] For about a three month period, November 1999 through January 2000, the resource nurses also designated a clinical technician as a “float” to assist others on the night shift. Making this assignment required the resource nurses to consider the motivation and work habits of the clinical technicians.

It is likely that at some future point, the resource nurses will not continue reporting employees who are tardy.

In the event that a staff member engages in serious misbehavior, the resource nurses are expected to intervene and take action to remove the offender from the area. Thus, the resource nurse could direct the offender to report to a break room, and summon security if necessary. The resource nurse is then to report the incident to the leads and/or Goda.

Discipline is handled by Goda with the participation of the leads. The leads counsel probationary employees and participate in the development of corrective plans of action and in determining the level of discipline imposed. The resource nurses do not participate in setting levels of discipline, or in imposing discipline.

The Employer has both 6-month and annual evaluations, and has annual raises which are independent of the evaluations. The 6-month evaluations for new staff are completed by the leads, and the annual evaluations are completed by Goda. The leads solicit input from the resource nurses on the 6-month evaluations.[23] However, Goda does not regularly solicit input from the resource nurses for the annual evaluations. Rather, it is only if Goda is not sufficiently familiar with a particular employee, that he may seek input from a resource nurse. Further, the resource nurses may volunteer information about staff to Goda, which he may take into account in making his determinations.

The Employer has a formal grievance procedure. It does not appear that the resource nurses have any role in that procedure. Further, while the resource nurses will attempt to resolve issues that arise over staffing or assignments, if the employees are not satisfied, they can bring the matter to Goda.

Goda carries a pager and has advised the staff that he is available 24 hours a day, 7 days a week. As noted, in Goda's absence, the leads perform his functions. The resource

[23] The record does not reflect the manner in which the 6-month evaluations are utilized, or the degree to which, if any, the input solicited is actually used by the leads.

nurses do not perform Goda's functions and they do not substitute for the leads if the leads are absent. If a resource nurse is absent, the position is filled by a former resource nurse. The leads do not substitute for the resource nurses. As noted, the resource nurses carry a cordless phone in the hospital, and there is a designated phone number. The resource nurses do not carry a pager when out of the hospital.

Goda communicates with the resource nurses by means of memos placed in a communications book and by means of occasional resource nurse meetings. In addition to holding memos from Goda, the communication book also serves as a means for the resource nurses to communicate among themselves. It is kept in the locked cabinet, which also holds the call off and tardy logs and the flex logs. Meetings of the resource nurses were held in February and December of 1998, and there have been one or two since then. The cardiopulmonary department as a whole holds monthly staff meetings covering both patient care and administrative matters.

b) The Critical Care Department

The critical care department is located on the first floor of the hospital and has 30 beds. The department is divided into three 6-bed pods or zones, which is considered the general critical care area, and a 12-bed pod for open heart surgery patients.

The critical care department is under the direction of Joni Meiter, who as noted, is the Director of Critical Emergency Care Services. Reporting to Meiter and responsible for the day to day operations of the critical care department is Assistant Director Terri Hardesty.

The department has a total staff complement of approximately 103 employees, consisting of 70 full-time staff nurses, 10 part-time staff nurses, 10 respiratory therapists, 7 administrative technicians and 6 resource or charge nurses (hereinafter charge nurses).[24] In general, if all beds are filled, on the daylight shift, each 6-bed pod has 3 nurses and the open

[24] In the critical care department, the names "resource nurse" and "charge nurse" are used interchangeably; however, charge nurse is the more common designation, and hence it is used herein.

heart pod has 5 nurses; on the afternoon shift, the 6-bed pods are staffed in the same manner, but the open heart pod has 4 nurses; on the night shift, the staffing pattern remains the same as the afternoon shift. Each shift has a charge nurse for the department as a whole, and in addition, one of the open heart pod nurses is also designated as the charge nurse for that area.[25] The staff nurse designated as the charge nurse in the open heart pod is selected by a consensus of the nurses working in that area. There is also one respiratory therapist assigned to the department, primarily to care for patients on ventilators and to draw blood gases.

The critical care department employs 6 charge nurses.[26] In general, these nurses work about 60 to 70 per cent of their scheduled shifts as charge nurses, and the remaining shifts as staff nurses. During vacation periods, these nurses work about 90 per cent of their scheduled shifts as charge nurses.

The charge nurses are selected by Meiter and Hardesty. They receive no special training in performing the duties of the position, but are required to be trained in the use of all the specialized equipment used in the department.[27] They receive no extra pay or benefits for their position. They are, however, given certain scheduling preferences in that they can not be required to give up assigned shifts when scheduling adjustments are made, they work every third weekend instead of every other weekend, and if they rotate, they are assigned more daylight shifts. The charge nurses have no special designation on their badges as to their position, but are designated as charge nurses on the assignment sheets. They carry a cordless phone and there is a designated phone number for them. The charge nurses basically self-select their schedule.

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[25] In discussing the duties and responsibilities of the charge nurses herein, all references are to the charge nurse for the department unless specifically identified otherwise.

[26] The charge nurses are Emma Adkins, Denise Cribbs, Curt Dehaven, Allison Melesky, Cindy Misorski and Scott Rolinson.

[27] Staff nurses are trained on specialized equipment on a voluntary basis as the need for more trained staff arises.

The charge nurses are not regularly assigned patients.[28] At the start of the shift, they receive report from the outgoing charge nurse, and they round the floor to assess the workload and identify issues, and provide hands on assistance as needed. They communicate with other resource nurses, particularly in the emergency department, the catheterization lab, and the operating rooms regarding the transfer of patients into the critical care department, and particularly with the cardiopulmonary department regarding the transfer of patients out of the critical care department.

The staff work schedules are prepared by Hardesty based upon self-schedules prepared by staff.

The charge nurses are responsible for handling call offs and obtaining replacement staff, if necessary, for the three 6-bed pods. However, the staff nurse who is designated the charge nurse in the 12-bed open heart pod is responsible for call offs in that area, but is expected to coordinate with the department charge nurse in this regard.

The charge nurses are responsible for making staffing adjustments to correspond to changes in the patient census with respect to the three 6-bed pods. The staff nurse functioning as the charge nurse in the open heart pod is responsible for handling the adjustments in that particular area, and is expected to coordinate with the charge nurse in this effort. The critical care department has its own written procedure to be utilized in making staffing adjustments. Factors considered in determining the appropriate level of staff include patient/staff ratio,[29] the actual census as well as anticipated changes thereto, patient acuity level and the use of specialized equipment.

[28] The charge nurse in the open heart pod is assigned a regular patient load.

[29] The general critical care staffing is a 2 to 1 patient/nurse ratio. Several situations require one to one staffing, such as a post-operative open heart patient, a post-code patient, a patient treated with a balloon pump, and a patient undergoing a specialized dialysis, unless the latter two patients are stable.

The adjustments are made in 4-hour increments, and the selection of nurses affected is based upon avoidance of overtime, restrictions limiting availability, training on specialized equipment, and when the employee was last impacted by an adjustment. In order to make these adjustments, the charge nurses have access to the ratios, records reflecting restrictions limiting availability, records of nurses trained on various equipment, and flex logs.[30] Volunteers are first solicited, and if there are not volunteers, an employee can be mandated to make the adjustment.

Requests by nurses to trade shifts are submitted to the charge nurses, who are authorized to approve them as long as they are equal trades, do not cross pay periods, do not result in overtime, and do not result in the absence of staff with specializing training that may be required. If these requirements are not met, the nurse requesting the trade must contact Hardesty.

Requests for PTO are made to Hardesty or Meiter directly, and if made to the charge nurse, the charge nurse consults with Hardesty or Meiter. However, on the offshifts or on weekends, when Hardesty and Meiter are not present, requests for PTO or to leave early for emergencies are made to the charge nurses, who grant such requests, and subsequently notify Hardesty or Meiter.

One of the functions of the charge nurse is to place patients in the department, and in an effort to utilize staff more effectively, the charge nurse may also consolidate patients on the three 6-bed pods, and if thereby possible, close one of the pods.[31]

The charge nurses in the critical care department assign nurses to patients. Thus, the charge nurse for the critical care department makes assignments of staff nurses to patients for the three 6-bed pods and the staff nurse designated as the charge nurse in the open heart pod

[30] These records are not kept in a locked area.

[31] Each pod must be staffed with two nurses even if there is only one patient on the pod.

makes the assignments for the open heart pod. If there are some patients in the open heart pod who are considered overflow from the regular critical care pods, both charge nurses coordinate the assignment for these patients. Among the factors considered in making the assignments are patient/nurse ratio, training required for specialized equipment, continuity of care, acuity of patients, and the skill and experience mix of nursing staff on a pod. These assignments are done for the next shift, and are modified during the day as patient needs require. Occasionally, the staff nurses will make changes to the assignments on their own. This appears to occur when the prior assignment sheet used as a reference by the charge nurse to insure continuity of care was not kept current as changes occurred, and the staff nurses change assignments so that they care for the same patients that they cared for previously.

The charge nurses do not schedule breaks or lunch for the staff nurses; rather, the staff nurses set their own times for breaks and lunch. The charge nurse may make temporary reassignments of staff nurses to cover for nurses taking breaks or lunch or may cover for the absent nurses themselves.

The charge nurses have been specifically directed not to intervene when a staff nurse is providing care, unless requested. Similarly, the charge nurses have been directed not to deal with staff behavior problems, or with physician complaints about nursing staff or equipment. All of these issues are to be reported to Hardesty or Meiter. With regard to physician complaints, if they arise on the offshifts or weekends, when Hardesty or Meiter are not available, the charge nurse must handle the matter. In addition, the charge nurses may also be required to validate that the staff nurses are able to perform certain tasks proficiently, if these are tasks that occur infrequently and the nurses are called upon to perform them on offshifts or weekends when Hardesty and Meiter are not present.

The charge nurses, as well as any staff involved, is responsible for completing incident reports documenting any unusual occurrence. These reports are provided to Hardesty for review, and she then forwards them to the Employer's risk management department.

Evaluations of staff nurses are prepared by Hardesty. Hardesty does not regularly solicit input from the charge nurses in preparing the evaluations, but may do so if she is not familiar with a nurse because the nurse works steadily on offshifts or weekends. However, as part of the evaluation process, a staff nurse has a right to have a peer perform an evaluation which becomes a component of the evaluation.[32] As noted, the Employer does not base its raises on the evaluations. Although Meiter testified that a poor evaluation could be used to withhold a raise, there is no evidence of this occurring.

Hardesty carries a pager. In her absence, the charge nurses do not perform her duties. If a charge nurse is absent, the duties are performed by another charge nurse, or by a former charge nurse. The charge nurses perform their administrative work in an area also utilized by the administrative technicians; the records used by the charge nurses in making staff adjustments or assignments are not kept in a locked area. Hardesty and/or Meiter hold monthly meetings for all critical care staff, as well as occasional meetings for specific staff, at times in response to a staff request. In the past year, there have been one or two meetings for charge nurses only.

c) The Emergency Department

The emergency department is located near the entrance to the hospital and consists of 15 rooms holding a total of 22 beds, with additional beds that can be placed in the hallways if needed. Rooms 1-4 are designated as trauma rooms, rooms 5-7 as monitor rooms, and room 15 as a psychiatric holding room; one of the other rooms is designated as a gynecological examination room.

[32] It appears that it is a hospital-wide practice that as part of the evaluation process, an employee may submit a peer review which becomes part of the evaluation.

This department is under the direction of Meiter, who as noted, is the Director of Critical Emergency Care Services.[33] Meiter is present in the emergency department on an irregular basis; on some days, she is not in the department at all, and on other days, she is in the department for 4 hours. Employed in the department are 7 charge nurses,[34] about 53-63 staff nurses, about 10 clinical technicians, about 20 administrative technicians, one administrative specialist, one quality assurance nurse, one clinical nurse specialist, and one billing employee. Also in the emergency department are physicians, nurse practitioners and physician assistants. Of the 7 charge nurses, 6 work full-time and one works part-time.[35]

The shift times in the emergency department are staggered to correspond to periods of high activity in the department. There is one charge nurse and one triage nurse on duty at all times while the number of staff nurses varies from about 4 to 6 and the number of clinical technicians varies. While Meiter estimated that the charge nurses work in that capacity 90 to 95 per cent of the time, one of the charge nurses testified that while she works as a charge nurse 90 per cent of the time, other charge nurses serve in that capacity 60 to 70 per cent of the time. If there is not charge nurse available, the most senior nurse on duty is designated the charge nurse.[36]

The charge nurses do not receive any specialized training for the position, and there is no evidence that they receive any additional pay or benefits. There is no identification of charge nurse status on their name badges, although they are designated as charge nurses on the schedules. The charge nurses on the daylight and afternoon shifts do not have regular assignments of patients, however the charge nurse on night shift does have a full patient

[33] The emergency department previously had an Assistant Director, but when the position became vacant in about January or February 2000, the decision was made not to fill the position.

[34] In the emergency department, the resource nurses are called charge nurses.

[35] The charge nurses are Amy Amato, Connie Compton, Teresa Farah, Susan Horvath, Anna House, B.J. Ryhal and Donna Seery.

[36] In the week preceding the hearing, there were 5 shifts that had no regular charge nurse working.

assignment. However, even when not assigned a full patient load, the charge nurses assist the staff nurses with direct patient care as necessary. While Meiter estimated that the charge nurses spend 90 per cent of their time at the nurses station, one of the charge nurses estimated that 30 to 40 per cent of the work time is devoted to patient care duties.

In the emergency department, the schedules for the nurses are prepared in the following manner. A blank schedule covering a 4-week period is posted and the nurses fill it in with their requested work shifts. Meiter has set the number of nurses that must be scheduled to work at any given time. Meiter has also set the number of nurses that can be on vacation at any given time, and nurses make vacation requests based upon seniority, giving them to charge nurse Amy Amato.

Using the schedule requests, the staffing guidelines, the vacation selection, and approved PTO, Amato prepares a 4-week schedule, making adjustments as necessary.[37] At the same time that Amato prepares the overall schedule, she also prepares daily staffing sheets reflecting the assignment of certain nurses to certain areas of the department, e.g., the trauma rooms. The schedule is then forwarded to Hardesty, the Assistant Director for the critical care department. Hardesty reviews the schedule to insure that it is fair and that there are no discrepancies in the way staff is scheduled, making further adjustments as necessary. She then enters the schedule in the computer.

The charge nurses in the emergency department are responsible for handling several aspects of staffing, including obtaining coverage to fill empty slots in the schedule, taking call offs and obtaining coverage, making adjustments based upon census and acuity, and handling requests to trade shifts and for PTO. With respect to gaps in the schedule, if there are gaps, a

[37] At one point, the schedule was prepared by the Assistant Director of the emergency department, but the duty was thereafter delegated to Amato, who at that point in time was a staff nurse. Amato subsequently became a charge nurse and has continued to prepare the schedule as described above.

list is posted and staff can sign up to work. Following guidelines on how this extra time is distributed, the charge nurses assign staff to these empty slots.

The charge nurses take call offs, and record the particulars of the situation. They next determine if it is necessary to obtain a replacement, which is usually the case, or whether they can work "short". In making this determination whether to replace a call off, and in obtaining a replacement, the charge nurses consider the same factors and follow the same procedures that they utilize in making staffing adjustments, described more fully below.

The charge nurses determine whether the daily staffing schedule of nurses and clinical technicians[38] must be adjusted, based upon staffing ratios, the patient census, anticipated changes to the census, and the acuity level of the patients. With respect to patient/nurse ratio, by virtue of the format of the daily assignment sheets, these sheets reflect the anticipated appropriate level of staffing for each area of the department in 4-hour increments. With respect to anticipated changes in the census, the charge nurse may receive telephone calls from nursing homes or physicians' offices as to admissions. The charge nurse is also in contact with resource nurses in other departments regarding the availability of beds in those departments and thus knows whether patients can leave the emergency department and be admitted to other departments.

The charge nurse may discuss the staffing situation with physicians, nurse practitioners, physician's assistants, staff nurses or clinical technicians, and solicit their input on staffing. It is relatively unusual to have to adjust the staffing downward, but this may occur if an additional person has been scheduled and the department is "quiet". It is more common to have to adjust the schedule upward, because of such factors as vacations or that the departments to which the emergency department usually admits patients, the critical care and cardiopulmonary

[38] The administrative technicians are responsible for making these determinations for themselves.

departments, are full and the emergency department has to hold these patients pending their admission elsewhere.

In implementing the decisions on staffing, the charge nurses follow a written flexing policy. This policy was developed by Meiter with input from the emergency department nurses. In obtaining a replacement for a staff nurse who called off, or in calling in additional nurses, the charge nurse would start with the p.r.n. nurses in order of seniority, then next determine which of the regular staff is not scheduled to work, any restrictions on working,[39] and who was last required to work. In replacing a triage nurse who called off, the charge nurse would first see if another triage nurse was available; if not, the charge nurse would only select a triage nurse from among the experienced staff. The charge nurse may place a nurse on call as opposed to having them present. The charge nurse first seeks volunteers before mandating a nurse to stay over and work.

At times, because of the situation, the charge nurse may deviate from this process, as for example, when there is a pressing need, and someone volunteers to stay out of order. As a result of replacing call offs, or adjusting the schedule for additional staff, overtime may be incurred, although the avoidance of overtime is one of the factors considered in selecting which staff are to work. If a nurse is mandated to work, but refuses to do so, the charge nurse does not issue discipline, but instead, refers the matter to Meiter.

As part of their staffing functions, the charge nurses may approve requests between nurses to trade shifts and requests for PTO. If these requests do not result in overtime, and if the request for PTO does not create a gap in the schedule,[40] the charge nurses routinely

[39] The charge nurses are informed of any restrictions, but not the reason therefore. In the emergency department, there is currently only one nurse who has medical restrictions affecting availability.

[40] The nurses in the emergency department generally find someone to cover for them if they are requesting PTO after the schedule has been made out.

approve the requests, otherwise, they are referred to Meiter. However, in rare situations, charge nurses have approved trades even though overtime was incurred.

One of the primary responsibilities of the charge nurse is to monitor and expedite the flow of the patients through the emergency department. As noted, the charge nurse may be aware of anticipated admissions to the department by receiving notification from nursing homes or physicians' offices. When patients comes into the emergency department, they are first seen by a triage nurse who assesses their condition, and based thereon, determines whether the patient can wait to be seen or requires immediate attention. If the patient requires immediate attention, the patient is taken to the charge nurse at that time. Further, if a patient comes into the hospital by ambulance, the patient is taken to the charge nurse. In either case, the charge nurse places the patient into a room in the appropriate area, for example, a trauma or monitored room. When placing the patient in a room, the charge nurse also designates, based upon acuity, which level of care is required in the first instance, i.e., whether the patient is seen by a physician, nurse practitioner, physician's assistant or nurse. As new patients come into the emergency department, the charge nurse may have to move patients to a different room. In this situation, the charge nurse would discuss the matter with the physician and the staff nurses.

If the physician decides to admit a patient, it is the administrative technician that contacts the floor and handles the arrangements. However, during the shift, the charge nurse is in contact with resource nurses in other departments regarding the availability of beds so that she can expedite the process.

As noted above, the nurses are already assigned to one of three specific areas of the department on the daily assignment sheet. Thus, by placing a patient in a particular room, the charge nurse has in effect assigned the nurses responsible for the care of the patient. In this regard, from the daily assignment sheet, it appears that at most, there could be 3 nurses working in an area. Depending on the particular situation, the nurses may decide between themselves which nurse will care for the patient, more than one nurse will provide care to the

patient, or the charge nurse will assign a nurse. If the charge nurse assigns a nurse to care for a patient, the charge nurse may take into consideration the workload of the nurses, the acuity of the patient, and the experience level of the nurse.

In some cases, the charge nurse may change the assignments of nurses from one area of the department to another area. For example, if as a result of staffing changes, there would be a p.r.n. nurse or an inexperienced nurse assigned to a trauma or telemetry room, the charge nurse would switch the assignment and place an experienced nurse in that area. Staff nurses can also agree between themselves to trade areas, without prior approval of the charge nurse, but informing the charge nurse of the trade.

The charge nurses do not assign lunch or break times to the staff nurses. Rather, these are decided by staff themselves. However, the charge nurse may request that the staff nurse take a break at a certain time, generally because the workload is lighter, or tell the staff nurse not to take a break at a certain time, again generally because of the workload.

Throughout the shift, the charge nurse may direct the staff to perform specific tasks. For example, the charge nurse may tell a staff nurse to discharge a certain patient or tell a clinical technician to do an EKG. According to Meiter, “sometimes, they even direct the physicians to get moving." The staff nurses can also direct the clinical technicians to perform specific tasks. If the charge nurse is aware of a performance problem with a nurse or clinical technician, she may discuss the situation with the employee and would report the problem to Meiter. Depending on the seriousness of the problem, Meiter may conduct an independent investigation and discipline the employee. The staff nurses can also report performance problems to Meiter, although that has not happened recently. If the problem would impair patient care, the charge nurse would intervene immediately, as would a staff nurse.

During the shift, the charge nurse will try to resolve any complaints made by the patient or family, as will the staff nurse in the first instance. The charge nurse will also try to address

complaints made by the staff about such matters as the workload. Ultimately, if the matters are not resolved, the charge nurse refers them to Meiter.

In order to apprise Meiter of the events that occurred on the shift, the charge nurses complete a report for Meiter detailing matters that arose on the shift, including issues the physicians raise, issues with patients, such as an angry family, staffing matters, such as call offs, unusual incidents, such as a patient leaving against medical advice and issues with the pharmacy and equipment. The charge nurse also gives report to the oncoming charge nurse. There are monthly meetings of all staff for the department conducted by Meiter.

d) The Psychiatric Department

The psychiatric department is a 15-bed locked unit located on the fourth floor of the hospital. The department is under the direction of Nurse Manager/Clinical Nurse Specialist Marcy Bartolovic, who reports to Vice President of Operations Fran Sheedy-Bost. The department employs about 29 employees, including about 10 staff nurses, 4 clinical technicians, 2 administrative technicians, 3 case managers, 3 resource nurses, one social worker and one certified occupational therapy assistant.

The schedule for the psychiatric department is based on an assumption of 10 beds occupied; however, since October 1999, the average census has been 9 or less and during December 1999, the average was 3 patients, during January 2000, the average was 6 patients and during February 2000, the average was 7 patients. Based upon 10 patients, the staffing is as follows: on the daylight shift, there are 2 nurses, one to 1 and ½ clinical technicians, one administrative technician, one case manager, one resource nurse, one social worker, and one certified occupational therapy assistant; on the afternoon shift, there are 2 nurses, one clinical technician, one administrative technician, and one case manager; on the night shift, there are 3 nurses. With 10 beds filled, there would be a resource nurse working on daylight, Monday

through Friday, and on afternoon, Monday through Friday about 30 to 50 per cent of the time.[41] However, when the patient census drops below 9, there is no resource nurse scheduled.

The case managers in the psychiatric department are responsible for evaluating patients in the emergency room and on the medical and surgical floors, and facilitating their treatment. The case managers are also responsible for performing utilization review functions. The nurses working the night shift have been cross-trained in the case manager's clinical functions so that they can perform evaluations if necessary.[42]

As set forth above, there are periods of time when there is no resource nurse scheduled, as on the night shift, on a substantial portion of the afternoon shifts, or any time when the census drops below 9. On those occasions, if there is a case manager present, the case manager performs the functions of the resource nurse to the extent that they are able to do so, including those related to scheduling and staffing.

As noted, there are 3 nurses designated as resource nurses, each of whom performs the functions of the position varying amounts of time. Thus, Bill Walker serves as a resource nurse for about 59 per cent of his working time, and works as a case manager or staff nurse the remaining part of his working time; Vicki Kleck, a part-time employee, serves as a resource nurse about 40 per cent of her working time, and works as a case manager or staff nurse the remaining time; and Pat Druzak serves as a resource nurse 10 to 20 per cent of her working time, and works as a case manager the majority of the remaining working time.

The resource nurses are selected and oriented by Bartolovic. They receive no extra pay or benefits for the position. Their name badges have the designation "Resource Nurse," but they wear the same badges whether they are working as a resource nurse or staff nurse. The resource nurses are not regularly assigned patients, but they are assigned a patient if

[41] Thus, it appears that it would be infrequent for a resource nurse to be scheduled at a time when there is no upper management present in the department.

[42] The case managers are included in the petitioned-for unit.

necessary and will assist staff nurses with patients as necessary. Similarly, staff nurses assist each other as needed.

The resource nurse handles call offs and staffing adjustments. Typically, the resource nurse does the staffing adjustment for the following shift, and thus, the day shift resource nurse makes the schedule adjustments for the afternoon shift, and the afternoon shift resource nurse makes the adjustments for both the night and day shifts. The resource nurse may also be required to modify staffing levels during the shift, and most commonly, this involves changes in the number of hours a clinical technician works.[43]

In making a determination of the appropriate staffing level, the resource nurses consider patient census and acuity. To guide the resource nurses in this regard, there is a grid which lists the appropriate staffing for a census from zero to 15, and which also contains a checklist of acuity indicators to be utilized in assessing acuity. This acuity checklist includes such items as the number of patients who have to be checked every 15 minutes per doctor's orders, number of incontinent patients, and the number of confused/wandering elderly patients. These indicators have been developed in the department over time using input from the staff. In making staffing adjustments, the resource nurses are to avoid overtime; however, they can incur overtime if necessary, but must document the situation.

In order to select which staff are impacted by the adjustments, the resource nurses consider health restrictions on hours or shifts worked,[44] as well as when the employee was last impacted by an adjustment. Volunteers are taken before an employee is mandated to adjust the schedule. Information on restrictions on working and tracking employees impacted is

[43] An example of a staffing adjustment made on the second shift would be if the census were low and the acuity was low, and there were 2 staff nurses, the administrative technician may be sent home at 6 p.m. and the clinical technician would perform both jobs until 9 p.m., at which time, the clinical technician would be sent home.

[44] The reasons for the restriction are not given.

contained in a schedule book, which kept at the desk where the resource nurses work. The schedule book is not kept in a locked area.

During the hearing, one of the nurses was questioned about staff complaints about being flexed down. She stated that ". . . I think all of us are pretty much aware of the fact that [the resource nurses'] decision is not guided by their independent knowledge. It's the fact that there's the grid, I had to do, you know, don't look at me and say I'm being mean to you, this is part of my job."

If disputes do arise over the implementation of the policy, they are handled by Bartolovic. Thus, one clinical technician refused the directive of a resource nurse to work in order to receive "show up" pay. Bartolovic counseled the technician because she had refused the directive to work. Bartolovic has also advised resource nurses to provide her with documentation of unusual staffing situations so that she can handle questions that arise.

The resource nurses can approve even trades or PTO, although such requests are normally made to Bartolovic.

The resource nurses are also responsible for making assignments of staff to patients, as well as other specific assignments described below. In making assignments, the resource nurse considers continuity of care, patient acuity and the resultant amount of time required to deliver care, and skills and experience of staff. In assessing acuity, the resource nurse considers the acuity indicators which are used to determine staffing adjustments. In assessing skill, the resource nurse may consider the ability of a particular nurse to work well with a particular type of patient.[45] The regular staff nurses have worked together in the department for at least 5 years so that experience is not an issue, unless there is a p.r.n. nurse who has not worked in the department recently. It is the policy of the department that staff preferences, such as a preference to work with certain age groups, are not to be considered. As a practical

[45] Although a patient may object to having a certain nurse, it is departmental policy to discourage reassignments on this basis.

matter, if there are 10 patients, the staffing guidelines would call for 2 nurses and one to 1 and ½ clinical technicians, so that the resource nurse would be actually looking at a limited number of options in making assignments. If there is a disagreement about staffing or assignments, the resource nurse attempts to resolve the problem in the first instance. If the resource nurse cannot resolve the matter, the resource nurse refers it to Bartolovic for resolution.

At times, staff nurses trade assignments. This occurs primarily if the resource nurse had for some reason not taken into account that the nurse had previously cared for the patient. In such a situation, the staff nurses do not seek prior approval of the resource nurse, but they do inform the resource nurse of the trade so that the records reflect the correct assignment. There is no evidence of a resource nurse refusing to permit the nurses to make such a trade.

During the shift, the resource nurse may assign staff to other tasks, such as sitting with a patient or accompanying a patient off of the floor. It appears that such assignments are made on the basis of the availability of staff to perform the task in question. The staff nurses also delegate tasks to other staff, as by asking a clinical technician to toilet a particular patient, so that the nurse can devote time to more specialized tasks.

The resource nurses also designate break and lunch periods and make special assignments, such staying in the patient dining room, conducting group therapies, and the order in which admissions are taken. With regard to designating breaks and lunches, the resource nurse asks the staff if they have a preference and makes the assignments accordingly. If however, there is a high level of acuity in the department, the preferences may be refused. With regard to the other special assignments, if their workload dictates, staff will trade special assignments among themselves. In the absence of a resource nurse, the staff decides among themselves the taking of breaks, lunches, and performing special assignments.

Bartolovic has delegated certain other administrative functions to the resource nurses, including a number of projects that were previously undertaken by the administrative specialist, a position which was abolished about May 1999. Among the tasks were the preparation of

schedules, verification of payroll records, and compilation of quality assurance data. Thus, Bartolovic has delegated to Kleck the responsibility for preparing the 4-week schedule. As noted above, this schedule is created based on an assumption of an average of 10 patients. The memo reflecting the delegation of duties states that the Nurse Manager/Resource Nurse are responsible for schedule creation.

Another duty previously performed by the administrative specialist and now performed by Druzak is the verification of payroll records. Although the hospital has recently implemented an automated time and attendance system, the psychiatric department has continued to use the prior paper timecards as well. Druzak is responsible for checking the paper timecard against the various staffing documents to verify the accuracy of the timecard for payroll purposes. If Druzak has questions, she refers them to Bartolovic. As part of her responsibilities in this regard, Druzak tracks attendance and tardiness. However, Bartolovic issues the discipline for absenteeism or tardiness.

Another duty previously performed by the administrative specialist and now performed by a resource nurse is the gathering of data and the preparation of various statistical reports, basically for quality assurance purposes.

Bartolovic has also made the resource nurses responsible for monitoring compliance with certain mandatory hospital policies. Thus, at Bartolovic's direction, Walker issued a memo reminding staff that the hospital required attendance at infection control inservices and requested that they apprise him when they attended the inservice. Similarly, at Bartolovic's direction, Druzak issued a memo scheduling staff to attend an infection control inservice. Also, after Walker discovered that staff were not following the hospital's policy on identification of patients with allergies, he brought the matter to Bartolovic's attention, and at her direction, he issued a memo to staff reminding them of the correct practice. In none of these instances did the resource nurses set policy; rather, they issued reminders of established policy and tracked

compliance with requirements. Further, the resource nurses do not issue any discipline for failure to meet these mandatory requirements; rather, Bartolovic would issue the discipline.

In a related matter, Bartolovic has also directed the resource nurses to revise extant departmental policies to reflect the current practice. In those situations, Bartolovic reviews and approves the revisions. Further, Bartolovic is responsible for deciding the correct interpretation of policy in the event clarification is needed, and she has made the resource nurses responsible for communicating a uniform interpretation of policy to staff.

During the shift, the resource nurses monitor the progress of the work of the staff, in part to determine who may need assistance. In so doing, the resource nurses may act as a "coach" to the other staff, offering suggestions as to ways to approach problems, including problems with family members. The resource nurses are sensitive to safety issues, and try to resolve them.[46] However, any problems that can not be resolved by the resource nurses are referred to Bartolovic. For example, one resource nurse repeatedly advised a particular staff nurse that it was not safe to interview patients in a small room. The nurse disregarded this advice and continued to conduct interviews in the room. The resource nurse then reported the matter to Bartolovic, who handled it.

Bartolovic has also directed the resource nurses to report on the performance of certain staff whom Bartolovic had previously counseled, in order to ascertain their progress. That is, if Bartolovic has counseled a staff member on a particular issue, Bartolovic may ask the resource nurse to observe the staff member and report to Bartolovic if there has been an improvement in a certain area. Such observations reported to Bartolovic by the resource nurse may be considered by Bartolovic in preparing an evaluation for the employee in question. [47]

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[46] All nurses are expected to address safety issues, and suggest ways to resolve problems with the delivery of care.

[47] There is no evidence that the resource nurses participate in the evaluation process in any other way. As part of the evaluation process, staff may solicit peer input which is made part of the process. In the evaluation of one nurse, who serves as a staff nurse and a case manager, Bartolovic informed the nurse

Bartolovic interviews candidates for job vacancies. She asks the resource nurses to meet with candidates and offer their impressions. Bartolovic also asks the staff nurses to meet with candidates and provide their impressions as well.[48] Finally, Bartolovic holds monthly meetings for all staff, as well as periodic meetings for the resource nurses.

e) The Medical/Surgical Departments

The general medical surgical services are provided by two departments, the ortho/neuro department and the gastro/uro surgical department which also includes oncology/metabolic. Both of these departments are under the direction of the Director of General Medical/Surgical Nursing Kathleen Brenner. Each of these departments is under the direction of an Assistant Director, who is responsible for the day to day operations of the department.[49]

The ortho/neuro department provides orthopedic and neurological services. It is a 59-bed unit located on the second floor of the hospital. The department is under the direction of Assistant Director Lydian Fisher, and employs about 52 nurses, 36 clinical technicians, administrative technicians, and a clinical nurse specialist. In this department, there are 11 resource nurses.[50] Based on an average patient census of 39, the daylight shift would be staffed with 7 nurses and 7 clinical technicians, the afternoon shift would be staffed with 6 nurses and 5 clinical technicians, and the night shift would be staffed with 4 nurses and 4 clinical technicians. In both departments, when there are an equal number of nurses and clinical technicians, they work as a pair, but if there are fewer clinical technicians than nurses,

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that Bartolovic had considered input from the resource nurse and from her peers, even though the nurse had not submitted any peer input.

[48] Notwithstanding Bartolovic's testimony on interviewing, the record also reflects that there have been no new hires in the department for 5 years.

[49] Brenner and the Assistant Directors each carry a pager and are each available 24 hours a day.

[50] The resource nurses are Karen Church, Linda Corless, Margaret Kiddey, Roxane Lapenta, Lisa McLean, Amy Moore, Pamela Puglise, Fran Sprowl, Nancy Stafford, Mary Ann Szymoniak, and Barbara Zebish.

as may occur on the off shifts, one clinical technician may be handling patients for more than one nurse.

The gastro/uro surgical department, along with the oncology/metabolic unit (herein GUS) is a 72-bed department situated on the first floor of the hospital. This department is under the direction of Assistant Director Karen Mayo and employs about 56 nurses, as well as clinical technicians, administrative technicians, a clinical nurse specialist and an administrative specialist. In the GUS department, there are 12 resource nurses.[51] Based on an average patient census of 49, on the daylight shift there are 10 nurses and 10 clinical technicians, on the afternoon shift, there are 7 nurses and 6 clinical technicians, and on the night shift there are 5 nurses and 5 clinical technicians.

There is a resource nurse scheduled to work in each department on the daylight and the afternoon shifts. On the night shift, however, there is no resource nurse scheduled, and one of the staff nurses is designated as the "Red Star". The Red Star has a full patient load and is also responsible for performing the duties of the resource nurse to the extent possible. Taking both departments together, there are about 10 nurses who generally serve as Red Stars.

At times, there is no resource nurse on the daylight or afternoon shift, and someone working as a staff nurse is designated as a Red Star. This can occur, for example, when a staffing adjustment must be made to increase nursing staff, and to avoid incurring overtime, the resource nurse will be required to work as a staff nurse, with a full patient load. In those instances, she would also be designated the Red Star and perform the resource nurse duties to the extent possible.

As part of the regular scheduling, the resource nurses are also assigned to work as staff nurses. They work about 30 to 40 per cent of their scheduled shifts as resource nurses and the

[51] The resource nurses are Brenda Alston, Kathleen Boring, BetteJean Davidson, Valerie Eberle, Cynthia Fisher, Cynthia Hancock, Faith Hoskinson, Katherine Krupa, Kathryn Licata, Annie Maura, Molly Romigh and Donna Spencer.

remaining shifts as a staff nurse. One resource nurse estimated that of her 5 scheduled shifts per week, she works one to 3 of them as a resource nurse. The resource nurses are specifically scheduled in this manner because of the high demands of the position. Further, if a resource nurse is scheduled to work a 12 or 16 hour shift, she will act as a resource nurse for only the first 8 hours, and as a staff nurse for the remainder of the shift.

New resource nurses are selected by Brenner and her Assistant Directors following an interviewing process.[52] Criteria in the selection are skills in problem solving, decision making, conflict resolution, organizing and prioritizing. The resource nurses have no special training, and are oriented to the position by shadowing a resource nurse for several days.[53] The resource nurses receive no extra pay or benefits for holding the position.

At the beginning of the shift, the resource nurses receive report from the offgoing resource nurse, and during the shift, they make rounds to assess the activity level of the department. The resource nurses do not have a regular patient assignment. However, as part of their duties as resource nurse they provide assistance to the staff nurses as needed. It is estimated that the resource nurses spend 75 to 90 per cent of their working time performing direct patient care or related activities, including helping with procedures, passing medications, processing admissions or escorting patients off of the unit.

The resource nurses do not participate in the preparation of the schedule. In each of these departments, the schedules are prepared by a scheduling team. In the ortho/neuro department, this scheduling team consists of two staff nurses, in the GUS department, the team consists of a staff nurse and a clinical technician.

[52] Most of the resources nurses have held this position or a variation of it for some time, and did not go through the current selection process.

[53] In 1996, 4 resource nurses attended a charge nurse training seminar, and thereafter, at a staff meeting, shared their experience with the other resource nurses.

The resource nurses are responsible for replacing call offs and making adjustments to the schedule. Adjustments to staffing are made by the resource nurse on the daylight shift for the afternoon shift, and by the resource nurse on the afternoon shift for the night shift. The resource nurse on the afternoon shift also prepares a skeleton staffing schedule for the staff nurse designated as the Red Star nurse on the night shift to use in preparing the staffing for the day shift. In determining whether to replace a call off and in adjusting the schedule, the resource nurse considers the actual census, anticipated changes to the census and the acuity of the patients. There are established staffing ratios[54] and grids available to the resource nurses detailing the number of nurses and the number of clinical technicians for a particular patient census. If Brenner or the Assistant Directors are present, they may participate in the staffing decision, as by directing a resource nurse to mandate a staff member rather than place her on call. The resource nurses and the Red Star nurse complete a report detailing the staffing during each 24-hour period.

After determining the appropriate level of staffing, the resource nurses select the staff impacted by adjustments. To the extent possible, they follow the flexing guidelines developed for the department. In general, if there is need for additional staff, they first contact the resource nurse on the other medical surgical department,[55] and see if the other department has excess staff. They then contact the house supervisor to see if p.r.n. staff is available. If not, they contact regular staff not scheduled to work. As a final resort, they turn to staff currently working. Volunteers are sought first, before mandating someone to stay over. In determining the selection of staff, the resource nurses can refer to various logs.[56] If a staff member refuses to

[54] The patient/nurse ratio on the daylight shift is 5 to 1, on the afternoon shift, 7 to 1 and on the night shift, 9 to 1. The patient/clinical technician ratio is, on the daylight shift, 5 to 1, and on the afternoon shift, 8 to 1.

[55] The ortho/neuro and GUS departments are considered sister departments.

[56] In the GUS department these logs are kept in an unlocked area. However, in the ortho/neuro department the logs are kept in a locked drawer because it was suspected that staff may have been altering the logs.

work although mandated to do so, the resource nurse does not impose discipline, but instead reports the matter to Brenner or the Assistant Director.

In adjusting the schedule, the resource nurses try to avoid overtime. However, as a result of the staffing adjustments, overtime may be incurred. To the extent that staff is volunteering for overtime, the resource nurses try to equalize the overtime among the staff.[57]

With respect to requests from staff to trade shifts and requests for PTO, the resource nurses in the ortho/neuro department do not approve such requests. Further, there is no evidence that the resource nurses in GUS participate in the approval of such requests.

The resource nurses determine where patients are placed in the department. This determination is controlled in the first instance by the availability of beds. The resource nurse will take into consideration the condition of the patient, such as not placing an infectious patient with a post-operative patient, the age and mental status of a patient, and trying to equalize the workload among staff. The resource nurse may consider the experience or specialized skills possessed by staff, such as not placing a ventilator patient in a room assigned to an inexperienced nurse.

In addition to placing patients within the department, the resource nurses in the two medical surgical departments may try to coordinate in which department the patient is placed. Thus, if one of the departments has all of its nurses at the maximum staffing ratio, instead of obtaining an additional nurse, as by bringing in the on-call nurse, the resource nurse on that department may contact the resource nurse on the other department to see if the other department can take the next admission.

The resource nurse assigns the staff to patients. The resource nurse considers continuity of care, acuity of patients to equalize workloads, experience and specialized training, and staff preferences. With respect to experience and skills, Brenner acknowledged that the

[57] Although the resource nurses formerly signed off on overtime logs, these logs are no longer maintained.

staff nurses on these two departments are "generally highly" experienced. The last new nurses joined the staff in about February or March 2000 and represent a small percentage of staff.[58] Further, to the extent that a patient's condition requires a nurse who has certain specialized training, as in chemotherapy, records identifying nurses with such training are available for the resource nurse. At times, Brenner or the Assistant Directors may leave a note for the resource nurse informing her that a certain staff member is not to be assigned to a particular patient, as when a patient refuses to have a certain nurse. In addition, the resource nurses will try to accommodate staff requests regarding patient assignments.

At times, the staff nurses will switch patient assignments. This would usually occur if the resource nurse was not aware that a certain nurse had cared for a particular patient on the prior shift.

The resource nurses will also assign specific tasks to staff, as by requesting that a clinical technician escort a patient that they are not assigned to care for, off of the floor. As noted, the staff nurses and clinical technicians work together as a pair and in so doing, the staff nurse routinely directs the work of the clinical technician.

While Brenner testified that the resource nurses assign breaks and lunch to the staff nurses and clinical technicians, and a resource nurse in the GUS department testified that she assigned the breaks and lunch for her department, a resource nurse in the ortho/neuro department testified that the administrative technician assigned the breaks and lunches for that department. Further, on the night shift, the Red Star assigns the breaks and lunch. Specifically, the resource nurse in GUS explained that she makes her assignments by just going 1, 2, 3, and that the staff switches among themselves and takes their break periods as their workload permits. The resource nurse on ortho/neuro explained that while the administrative technician

[58] In this regard, the record discloses that the turnover is less than 8 per cent. Further, all new nurses have completed a 12-week orientation.

assigned the breaks and lunches, the staff actually decided among themselves when to take the breaks.

All discipline is handled by Brenner. While the resource nurses can make suggestions to the staff, they do not participate in the disciplinary process. Evaluations are performed by Brenner with the assistance of the Assistant Directors, and the resource nurses do not participate in the evaluation process.

If there are complaints from patients, family members or physicians, in general, the staff nurses will attempt to resolve them. If the staff nurses are unsuccessful, they may refer the complaint to the resource nurse, who will try to resolve the matter. If the resource nurse cannot resolve the problem, she will refer it to Brenner or the Assistant Directors. If the patient or family complains to the resource nurse about the nurse assigned to care for the patient, the resource nurse may reassign the nurse to a different patient.

There are monthly staff meetings for each department and occasional meetings for the resource nurses, at which time issues of particular concern to them are addressed.

Analysis

To meet the statutory definition of a supervisor, a person needs to possess only one of the specific criteria listed in Section 2(11) of the Act, or the authority to effectively recommend such action, so long as the performance of that function is not routine but requires the use of independent judgment. Providence Hospital, 320 NLRB 717 (1996), enf'd. 121 F.3d 548 (9th Cir. 1997).

In determining the supervisory status of nurses, the Board applies its traditional analysis for determining the supervisor status of employees in other occupations. That analysis entails an inquiry into whether the employee at issue exercises independent judgment in connection with one, or more, of the functions listed in Section 2(11) of the Act. Moreover, an employee's exercise of ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards is not the exercise of

independent judgment that makes an employee a supervisor under Section 2(11). See Providence Hospital, supra at 725-730; Nymed, Inc., d/b/a Ten Broeck Commons, 320 NLRB 806, 809-812 (1996). See also Rest Haven Living Center, Inc. d/b/a Rest Haven Nursing Home, 322 NLRB 210, 211 (1996).

Applying the traditional test of supervisory status, the burden of proving supervisory status rests with the party asserting that status. Vencor Hospital – Los Angeles, 328 NLRB No. 167 slip op. at 3 (1999). Thus, in this case the Employer must demonstrate that the resource nurses exhibit at least one of the twelve statutory indicia of supervisory status and that this attribute is exercised using independent judgment. [59]

There is no contention that the resource nurses have the authority to hire, transfer, layoff, recall, promote or to effectively recommend such action. The Employer primarily contends that the resource nurses responsibly direct and assign employees and that their exercise of such authority requires the use of independent judgment. The Employer, at least by implication, would apparently assert that the resource nurses have the authority to effectively recommend suspension and discharge by reporting refusals to work mandatory shifts to admitted supervisors; that the resource nurses have the authority to effectively recommend discipline by reporting performance problems to admitted supervisors; that the resource nurses

[59] In its brief, the Employer relies on cases from the United States Courts of Appeal in the Third, Fourth and Sixth Circuits finding charge nurses to be supervisors, and does not address the Board's decision in Providence Hospital. It is the duty of the Board to establish a uniform labor policy, as distinct from a patchwork of geographically distinct rules. Manor West, Inc., 311 NLRB 655, 667 fn. 43 (1993). It should also be noted that the Board's position on the supervisory status of charge nurses has been upheld by the Seventh, Eighth, Ninth and District of Columbia Circuits. Moreover, the Board has recently stated that it will continue to adhere to the principles set forth in Providence Hospital concerning the supervisory status of charge nurses, notwithstanding the decisions of certain circuit courts of appeals to the contrary. Vencor Hospital – Los Angeles, supra at fn. 9 Therefore, the Board's precedents are controlling herein, notwithstanding seemingly conflicting rulings by certain courts of appeals. It is long established that Board precedent which has not been reversed by the Board or the United States Supreme Court is to be followed, even in light of contrary authority in the courts of appeals.

have the authority to effectively recommend rewards by giving input to admitted supervisors preparing evaluations; and that the resource nurses adjust grievances.[60]

Each of the departments at issue herein has managerial personnel responsible for the day to day operations of the department. Thus, the cardiopulmonary, critical care and two medical/surgical departments each have their own Assistant Directors, the psychiatric department has a Nurse Manager, and the emergency department is under a Director. The cardiopulmonary department also has two leads. These personnel are generally available during the weekdays. On the off shifts and weekends, there is a house supervisor available in the hospital. In addition, in the cardiopulmonary and critical care departments, the assistant directors are available by pager when not in the hospital.[61] When the resource nurses are the highest ranking person in the department, they are not delegated any greater authority than they have when admitted supervisors are present, except for the approval of even trades and PTO that had not been requested in advance. The presence or availability of admitted supervisory personnel thus imposes institutional limits on the authority of the resource nurses.[62]

Resource nurses are not scheduled to work on every shift and in every area. Thus, it is only the emergency and cardiopulmonary departments which have resource nurses scheduled to work on every shift. On the other hand, the critical care department has a resource nurse scheduled to work on every shift in the general area, but does not have a resource nurse in the open heart area. Further, the medical/surgical departments have a resource nurse scheduled on day and afternoon shifts, but not on night shift. Finally, the psychiatric department has a resource nurse scheduled on day shift during the week, on afternoon shift 30 to 50 per cent of

[60] The Employer relies upon various "job descriptions" which purport to list the duties and responsibilities of the resource nurses in different departments. To the extent the duties listed in these documents do not comport with the testimony of the witnesses regarding the actual functions of the job, the documents have little probative value. Sunset Nursing Homes, Inc. d/b/a North Miami Convalescent Home, 224 NLRB 1271, 1272 (1976).

[61] The record does not reveal if the other managerial personnel are also available by pager.

[62] See e.g., Children's Habilitation Center, Inc. v. NLRB, 887 F.2d 130, 133, 134 (7th Cir. 1989).

the time during the week, as long as the census is above 9, but has no resource nurse scheduled otherwise. In addition, even when there is a resource nurse scheduled, as a result of call offs or staffing adjustments, there are times when the scheduled resource nurse is working as a staff nurse.

In the absence of a regularly scheduled resource nurse, the functions of the resource nurse are performed by staff nurses and not by management personnel. For example, in the open heart area of the critical care department, one of the staff nurses is designated as the resource nurse; in the psychiatric department, the case manager performs the resource nurse functions, and in the medical/surgical departments, a staff nurse is designated the Red Star and performs the resource nurse duties. In other situations, a staff nurse will perform the resource nurse functions.

In addition to staff nurses performing the duties of the resource nurses on a regular basis, the resource nurses themselves are not always scheduled to work as resource nurses, but are scheduled to work the remainder of their shifts as staff nurses. The amount of time the resource nurses work as resource nurses varies with the department. In the emergency department, it is estimated that resource nurses are scheduled as resource nurses 60 to 95 per cent of their shifts; in the critical care department, the estimate is 60 to 70 per cent, except during vacation periods when the percentage increases to 90 per cent; in the cardiopulmonary department, the estimate is 50 per cent; in the psychiatric department, the estimates range from 10 to 59 per cent; and in the medical/surgical departments the estimate is 30 to 40 per cent. Further, even when working as resource nurses, the resource nurses spend a substantial part of their workday assisting staff nurses by providing hands on patient care.

The resource nurses receive no additional pay or benefits for being a resource nurse. They have no specialized training or education for the position.

The staffing for each department at issue herein is initially set on a 4-week schedule. These schedules are built based on an average departmental census and staffing ratios, both of

which are determined by upper management. In general, the staff makes requests to work certain days and shifts, as well as to take certain time off for vacations and PTO, and the department head determines the number of staff that can be on vacation at any time, and approves PTO requests made in advance.

The responsibility for the actual preparation of the schedule varies by department. Thus, in the cardiopulmonary and critical care departments the schedules are prepared by the Assistant Directors of each department; in the emergency and psychiatric departments, the schedules are prepared by resource nurses, and in the two medical/surgical departments, the schedules are built by teams, consisting in one instance of two staff nurses and in the other instance of a staff nurse and a clinical technician. Regardless of who prepares the schedule, it is clear that their authority is severely circumscribed by the institutional controls built into the process.

The resource nurses make adjustments to the schedule to correspond to deviations in the census from the projected average census upon which the schedule was built. If adjustments are required, they first determine the appropriate staffing level, and then select the staff members. Thus, they begin with the actual census and factor in anticipated changes due to admissions, discharges and transfers. They check the established patient/staff ratio and consider whether the acuity level of the patients and resulting workload would warrant a deviation from the staffing ratio. In this regard, it is noted that the staffing ratios are set by management, and take into account the general acuity of patients in different departments. For example, the patient/nurse ratio on daylight shift in critical care is 2 to 1 while the patient/nurse ratio in the general medical/surgical departments on daylight shifts is 5 to 1.

After the staffing level is set, the resource nurse implements that level, adjusting the staff upwards or downwards. Staff is selected in accordance with established policies and procedures, which are designed to insure uniformity in application and to affect staff in an equitable manner. These policies are in writing, and individualized to meet the needs of each

department. They spell out, in detail, the particular steps a resource nurse must go through in adjusting the schedule.

In making the adjustments, the resource nurse may have to take into account various limitations on the work availability of staff, and specialized training required for patient care. All of this information, such as when an employee was last mandated to stay over, any medical restrictions on the number of shifts an employee can work, and specialized training a nurse has received, is contained in various logs and records available to the resource nurse. It is noted that the information made available to the resource nurses about restrictions which limit the availability of employees to work certain shifts, such as restrictions for medical reasons, is specifically limited so as not to disclose confidential information as to the reason for the restriction. As part of this staffing process, the resource nurse handles call offs, utilizing the same procedures. Generally, the resource nurses may approve requests between nurses to trade shifts or days, as long as the trades are even trades, and to approve requests for PTO, usually for immediate use as in connection with a call off.

As a result of the application of this process, the Employer may incur overtime and employees may be mandated to work. However, the process is designed to avoid overtime, and to avoid mandating employees. Moreover, to the extent that there is overtime or employees are required to work beyond their shift, it is a function of the process, rather than as a result of the exercise of independent judgment of the resource nurse. In addition, if an employee refuses to work although mandated to do so, the resource nurse does not issue any discipline, but instead reports the refusal to admitted supervisory personnel.

In sum, these scheduling duties require the consideration of many variables. However, the hospital and each department at issue herein have established extremely detailed policies and procedures, which are designed to insure uniformity and fairness in scheduling. Assessing whether there is high or low patient census is essentially a tracking function, assessing acuity is

part of the professional responsibility of a nurse,[63] and selecting staff is essentially a tracking function. These are, in short, duties that can be performed by any appropriately trained employee.

The duties of the resource nurses with respect to scheduling are not significantly different from the functions performed by a dispatcher in the trucking industry or by an expediter or inventory control specialist in a manufacturing facility, positions which the Board has long recognized to be non-supervisory. The resource nurse is, as one resource nurse testified, a "glorified traffic cop". See Providence Hospital, supra at 732.

The resource nurse also is responsible for placing patients within the department. In placing patients, the resource nurse considers the availability of beds and the patient's condition. As a corollary to placing the patients, the resource nurse also makes daily assignments as to which nurses will care for which patients.

The daily assignment of nurses to patients is based upon considerations of continuity of care, acuity of patients and resultant level of care, experience, specialized training or skills and staff preferences. Continuity of care is based upon the prior assignment records. Patient acuity is considered to equalize workloads, and, like the resource nurses, the staff nurses regularly assess the patients' needs and acuities. In fact, the resource nurses' assessments of acuity are in many instances derived from the staff nurses' report of their own assessments rather than from the resource nurses' independent determination. The assessment of patients' needs and acuities is part of the professional responsibility of all nurses. Also, there is no basis for concluding that the resource nurses are any more knowledgeable about the skills of the staff nurses than the staff nurses themselves. In this regard, the differences in skills possessed by a new graduate and a long-term staff nurse in the department are obvious and would be well-known, and any specialized training possessed by a particular staff nurse is documented. Thus,

[63] As noted, in the psychiatric department, even the assessment of acuity has been reduced to a resource nurse checking off the presence of specific acuity indicators.

the assignments do not require any independent judgment that goes beyond the professional judgment exercised by all nurses. These assignments do not involve the independent judgment exercised by a supervisor. Providence Hospital, supra at 731-732; Clark Machine Corporation, 308 NLRB 555, 555-556 (1992).

It appears that the timing of breaks and lunches is almost entirely determined by the workload. Thus, in most of the departments at issue herein, breaks and lunches not assigned by the resource nurses, but instead the staff decides when they will take breaks and lunches. This is the practice followed in the cardiopulmonary, critical care and emergency departments. In these departments, however, the resource nurse may request that breaks or lunches be taken at different times, again because of the workload. In the psychiatric department, the breaks and lunches are assigned by the resource nurse, but the resource nurse assigns them based upon staff preference. In the GUS department, the resource nurse assigns the breaks and lunches, but in the ortho/neuro department, the administrative technician assigns them. In sum, to the extent that breaks and lunches are assigned by resource nurses, they make such assignments based upon the workload; this is a routine clerical judgment, not conferring supervisory status. Providence Hospital, supra at 732.

The resource nurses monitor other employees' skills and performances, intervene in the case of serious problems, and report lesser problems to admitted supervisors. This monitoring of employees' skills by the resource nurses is a routine function of their professional responsibilities as nurses and is shared by all nurses. As part of their functions, the resource nurses try to resolve complaints from patients, family members, physicians, and staff. Staff nurses, however, are also expected to report any problems in the delivery of care, and attempt in the first instance to address complaints. In this regard, it is noted that the resource nurses do not discipline or evaluate employees. At most, they perform reportorial functions, relaying

factual information to admitted supervisors.[64] Staff nurses also report problems to management, which likewise can be the basis for disciplinary action. Staff nurses may also provide peer input on evaluations. The Board has held that the direction of employees, as occurs herein, is merely of a routine and clerical nature, and does not require the use of independent judgment within the meaning of Section 2(11) of the Act. Providence Hospital, supra at 733.

As in Providence Hospital, the resource nurses herein serve as team leaders responsible for coordinating work and serving as a center of communication, which is especially demonstrated by the rotational assignment of nurses as resource nurses. In this regard, as set forth in detail above, the staff nurses are regularly called upon to perform the functions of the resource nurse, particularly in the open heart surgery area, in the psychiatric department on the afternoon and night shifts, and in the medical/surgical floors on the night shift, and in all departments when a resource nurse is unavailable. On the other hand, the resource nurses work a substantial portion of their assigned shifts as staff nurses, and even when scheduled as resource nurses, spend a substantial part of their worktime performing hands on patient care side by side with the staff nurses. The fact that both the resource nurses and the staff nurses have the same training and receive the same compensation further demonstrates that there is no difference between them. A finding that the resource nurses are statutory supervisors, based upon their duties as set forth above, would effectively mean that all nurses who perform these functions would be deemed supervisors, an anomalous and impractical result which is not required by the Act. Statutory authority is not shown by the limited authority of a resource nurse on one day to "supervise" coequal nurses, some of whom on another day "supervise" their

[64] There is no evidence that the resource nurses make any recommendation as to discipline in making factual reports to management. See Vencor Hospital – Los Angeles, supra slip op at 4; Passavant Health Center, 284 NLRB 887, 889 (1987). With respect to the evaluations, there is no evidence that the evaluations are used to establish wage increases (except for the conclusory testimony of one director that notwithstanding the Employer's automatic grant of wage increases, a raise could be withheld based on an

equals including the resource nurse. Providence Hospital, supra 733; General Dynamics Corporation, 213 NLRB 851, 859 (1974).[65]

In sum, the functions performed by the resource nurses, particularly those related to the scheduling of staff, while exceedingly important to the efficient and cost-effective operation of the hospital, are not supervisory functions. The nurses herein are supervised by the department directors, the assistant directors (or nurse manager) and the lead nurses, all of whom have the powers set forth in Section 2(11) of the Act. In contrast, these supervisory powers are not vested in the resource nurses by virtue of their duties as set forth herein.[66]

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evaluation), promotions, retention and the like. See Harborside Healthcare, Inc., 330 NLRB No. 191 (2000).

[65] The Employer's reliance on NLRB v. Attleboro Ltd., 176 F.3d 154 (3rd Cir. 1999) is misplaced. In Attleboro, the United States Court of Appeals for the Third Circuit (herein Third Circuit) found, contrary to the Board, that LPN charge nurses in a nursing home were supervisors, in part, based upon their assignment and direction of CNAs. However, the Court stated that the Ninth Circuit decision enforcing Providence Hospital was distinguishable. The Court noted that in Providence Hospital, the disputed charge nurses were supervising other nurses and in many ways were "one of the gang". In contrast, the Court noted that in Attleboro, the LPN charge nurses were not "one of the gang" with the CNAs. In the instant case, as in Providence Hospital and in distinction from Attleboro, the resource nurses serve as staff nurses a substantial portion of their shifts, and as detailed above, all nurses share many of the same responsibilities.

Further, Passavant Retirement & Health Center v. NLRB, 149 F.3d 243 (3rd Cir. 1998) upon which the Employer relies, is also inapposite. In Passavant, the Third Circuit held that LPN charge nurses in a retirement community were supervisors based upon their authority to discipline aides and adjust their grievances. As in Attleboro, the Court in Passavant was not faced with coequal employees as in the instant case. Further, in the instant case, the asserted bases for the supervisory status of the resource nurses are primarily the assignment and direction of work, which were not in issue in Passavant.

Finally, NLRB v. Prime Energy Limited Partnership, 2000 WL 1123503 (3rd Cir. August 9, 2000) also cited by the Employer, is factually distinguishable in several significant respects. In Prime Energy, the Third Circuit held that shift supervisors in an electric generation plant were supervisors based, in part, upon their assignment of work to the plant operators and the direction of that work, "particularly in the event of an emergency." The Court noted that the shift supervisors were "responsible for the safe operation of the facility." Certainly, the resource nurses herein have no comparable responsibility. Moreover, as with the preceding two Third Circuit decisions, the Court in Prime Energy was not faced with coequal employees, and additionally the shift supervisors received a 15 per cent pay differential, were eligible for bonus pay, had more advantageous insurance coverage and accumulated sick days from year to year, all of which the plant operators did not. Here, the resource nurses are coequal with the staff nurses in every respect.

Moreover, the Board has recently stated that it will continue to adhere to the principles set forth in Providence Hospital concerning the supervisory status of charge nurses, notwithstanding the decisions of certain circuit courts of appeals to the contrary. Vencor Hospital – Los Angeles, supra at fn. 9

[66] While the Employer urges that it would be "absurd" to believe that the operation of a department is supervised by one person, I note that, as the Third Circuit observed in Attleboro and Prime Energy, ratio

Based upon the above and the record as a whole, I find that the resource nurses are not supervisors as defined in the Act, and I shall include them in the petitioned-for unit.

Accordingly, I find that the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time and regular part-time registered nurses, including the classifications of Resource Nurse, Clinical System Analyst, Disease Management Coordinator, Case Management RNs, RN-Peri/Op Facilitator, Nurse Anesthetist, RN Nerve Block Assistant, IV Therapists, Review Nurse, Nurse Practitioner, Blood Bank RN, Staff Nurse-Card/DI, Cardiac Rehab Nurse, Case Management/Wellness Center, ET Nurse, Family Planning Nurse, Family Planning Nurse Practitioner, Family Practice Nurse, Family Practice Nurse Practitioner, Clinical Process Coordinator, Educator RN, and Organizational Development Specialist RN, employed by the Employer at its facilities located at 1000 Dutch Ridge Road, Beaver, Pennsylvania, in Beaver Falls, Pennsylvania, and in Hopewell, Pennsylvania, excluding all office clerical employees, managerial employees, Clinical Nurse Specialists, Lead Nurses and the Employee Health Nurse, and guards, other professional employees and supervisors as defined in the Act and all other employees.

DIRECTION OF ELECTION

An election by secret ballot will be conducted by the undersigned Regional Director among the employees in the unit set forth above at the time and place set forth in the Notice of Election to be issued subsequently, subject to the Board's Rules and Regulations.[67] Eligible to vote are those employees in the unit who were employed during the payroll period immediately

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is not one of the criteria of supervisory status identified in the Act. Accordingly, while I have observed that the Employer's position would effectively result in all staff nurses performing the duties of the resource nurses being deemed supervisors, my finding that the resource nurses are not supervisors is not based on the ratio that would result in that situation.

[67] Pursuant to Section l03.20 of the Board's Rules and Regulations, official Notices of Election shall be posted by the Employer in conspicuous places at least 3 full working days prior to l2:01 a.m. of the day of the election. As soon as the election arrangements are finalized, the Employer will be informed when the Notices must be posted in order to comply with the posting requirement. Failure to post the Election Notices as required shall be grounds for setting aside the election whenever proper and timely objections are filed. The Board has interpreted Section 103.20(c) as requiring an employer to notify the Regional Office at least five (5) full working days prior to 12:01 a.m. of the day of the election that it has not received copies of the election notice.

preceding the date below, including employees who did not work during that period because they were ill, on vacation or temporarily laid off. Also eligible are employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period and their replacements. Those in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are employees who have quit or been discharged for cause since the designated payroll period and employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced.[68] Those eligible shall vote whether or not they desire to be represented for collective bargaining by District 1199P/Service Employees International Union, AFL-CIO, CLC.

Dated at Pittsburgh, Pennsylvania, this 28th day of August 2000.

/s/Gerald Kobell
Gerald Kobell
Regional Director, Region Six

NATIONAL LABOR RELATIONS BOARD
Room 1501, 1000 Liberty Avenue
Pittsburgh, PA 15222

177-8560-1000
177-8580-8060

[68] In order to assure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses, which may be used to communicate with them. Excelsior Underwear, Inc. 156 NLRB 1236 (l966); NLRB v. Wyman-Gordon Company, 394 U.S. 759 (l969). Accordingly, it is hereby directed that the election eligibility list, containing the full names and addresses of all eligible voters, must be filed by the Employer with the Regional Director within seven (7) days of the date of this Decision and Direction of Election. The Regional Director shall make the list available to all parties to the election. In order to be timely filed, such list must be received in the Regional Office, Room l50l, l000 Liberty Avenue, Pittsburgh, PA l5222, on or before September 5, 2000. No extension of time to file this list may be granted, except in extraordinary circumstances, nor shall the filing of a request for review operate to stay the requirement here imposed.